

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455486	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/27/2024
NAME OF PROVIDER OR SUPPLIER Ennis Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1200 S Hall St Ennis, TX 75119	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44671</p> <p>Based on interview and record review, the facility failed to notify a representative of the Office of the State Long-Term Care Ombudsman, for 1 of 1 resident (Resident #1) reviewed for discharge.</p> <p>The facility initiated a 30-day discharge for Resident #1 on 12/10/2024 and did not notify the State Long-Term Care Ombudsman by phone or in writing.</p> <p>This failure could place residents at risk of improper discharge planning and diminished quality of life.</p> <p>Findings included:</p> <p>A record review of Resident #1's face sheet undated reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #1's diagnoses were Alzheimer's disease (type of dementia that affects memory, thinking, and behavior), dementia (memory loss), and major depressive disorder (loss of interest in activities).</p> <p>A record review of Resident #1's Quarterly MDS assessment, dated 09/26/2024, reflected the resident had a BIMS score of 3, which indicated severe cognitive impairment.</p> <p>Review of Resident #1's 30-day discharge letter dated 12/10/2024, revealed Resident #1 was given the 30-day discharge letter on the same date (12/10/2024) she was discharged to the hospital.</p> <p>Review of Resident #1's Discharge Planning and Summary date 12/10/2024, revealed Resident #1 was sent to the hospital for behaviors.</p> <p>Attempted an interview on 12/27/2024 at 10:49 a.m. left message for the local ombudsman to return call.</p> <p>Record review of Resident #1's chart did not reveal any notification to the Ombudsman.</p> <p>Record review of Resident #1's progress notes, dated 12/10/24, charted by DON reflected, discharged to hospital.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 12/27/2024 at 4:56 p.m., the SW stated she was aware a resident is given a 30 days notice prior to discharge, The SW stated she was not made aware Resident # 1 was being discharged on [DATE] until she was sent out to the hospital. The SW stated if she would have been made aware of the discharge she would have assisted in finding safe placement for Resident # 1. The SW stated she did not assist with the immediate discharge and she did not have any knowledge of.</p> <p>During an interview on 12/27/2024 at 6:00 p.m., the OM stated he did not contact the local ombudsman of the immediate discharge. The OM did not give a reason to why the local ombudsman was not contacted. The OM stated he thought he could issue a 30 days discharge immediately when it was behavior related. The OM stated he know to follow the provider letter when issuing 30 day discharges.</p> <p>Review of long-term care regulation provider letter dated 12/29/2022 reflected If a NF initiates a resident discharge, the facility must provide written notification of the discharge-in a language and manner the resident can understand-to the resident, the resident representative (if applicable), and a representative of the Long-Term Care Ombudsman Program, at least 30 days before the intended discharge date . A NF is required to provide a resident with enough preparation regarding his or her discharge so that it may be safe and orderly.</p>		

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<p>F 0624</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Prepare residents for a safe transfer or discharge from the nursing home.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44671</p> <p>Based on record review and interviews, the facility failed to provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility for one (1) of one resident reviewed for transfer and discharge rights. (Resident #1)</p> <p>The facility failed to make arrangements for a safe discharge for Resident #1.</p> <p>This failure could place residents at risk for not receiving care and services to meet their needs upon discharge.</p> <p>Findings included:</p> <p>A record review of Resident #1's face sheet undated reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #1's diagnoses were Alzheimer's disease (type of dementia that affects memory, thinking, and behavior), dementia (memory loss), and major depressive disorder (loss of interest in activities).</p> <p>A record review of Resident #1's Quarterly MDS assessment, dated 09/26/2024, reflected the resident had a BIMS score of 3, which indicated severe cognitive impairment.</p> <p>Review of Resident #1's 30-day discharge letter dated 12/10/2024, revealed Resident #1 was given the 30-day discharge letter on the same date (12/10/2024) she was discharged to the hospital.</p> <p>Review of Resident #1's Discharge Planning and Summary date 12/10/2024, revealed Resident #1 was sent to the hospital for behaviors.</p> <p>Attempted an interview on 12/27/2024 at 10:49 a.m. left message for the local ombudsman to return call.</p> <p>During an interview on 12/27/2024 at 12:45 p.m., the FM stated she or the RP never received a call that the resident was being transferred out of the facility and was not able to return. The FM stated on 12/10/2024 at 2:00 p.m., The OM had left a voice message stating Resident #1 was sent out to the hospital for behaviors. The FM stated Resident # 1 had dementia and was not able to understand. The FM stated Resident # 1 was admitted to the hospital 12/10/2024 and was released on 12/13/2024. The FM stated the OM stated Resident #1 was not allowed back at the facility due to her behaviors. The FM stated that Resident # 1 was safe and was admitted to another nursing facility on 12/13/2024. The FM stated that it was very unacceptable to not notify the family and let them know Resident # 1 was not able to return to the facility after being sent out to the hospital.</p> <p>(continued on next page)</p>		

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<p>F 0624</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 12/27/2024 at 4:56 p.m., The SW stated that Resident # 1 had a history of behaviors but she did not know Resident # 1 was being discharged on [DATE] to the hospital. The SW stated if she had been made aware of Resident #1 being discharged , she would have assisted with finding a safe place for Resident #1. The SW stated the OM was responsible for distributing the 30-day notice and notifying Resident # 1 and her RP. The SW stated it was expected to give a 30-day notice to make the family aware of Resident #1 being discharged . The SW stated not providing a 30-day's notice does not give time to find the resident placement.</p> <p>During an interview on 12/27/2024 at 5:20 p.m., The BOM stated she was notified on 12/10/2024 through teams 'application that Resident #1 was going to be discharged to the hospital. The BOM stated she was aware Resident #1 was not returning to the facility due to behaviors. The BOM stated a 30-day discharge was given prior to Resident # 1 leaving for the hospital.</p> <p>During an interview on 12/27/2024 at 5:45 p.m., The DON stated that Resident # 1 did not have a medical emergency but was sent out to the hospital for behaviors. The DON stated Resident # 1 was issued an immediate discharge on 12/10/2024 the same day she had left for the hospital. The DON stated Resident # 1's behaviors were a risk to residents and she was not able to return to the facility.</p> <p>During an interview on 12/27/2024 at 6:00 p.m., The OM stated that Resident #1 was sent out to the hospital for behaviors and no medical emergency. The OM stated Resident # 1 was given a 30-day notice when she left for the hospital on 12/10/2024. The OM stated Resident # 1 was not allowed to come back due to her behaviors. The OM stated it was expected to give a 30-days' notice and he had followed the provider letter. The OM stated he thought he could use an immediate discharge when there is a behavior with a resident, and you want to be able to keep all residents safe. The OM stated he tried to reach the RP by phone but was unable to reach the RP, and he left a message to advise Resident #1 had been sent out to the hospital. The OM stated when a 30-day's notice was not given you would not have time to find safe placement for a resident.</p> <p>Review of long-term care regulation provider letter dated 12/29/2022 reflected If a NF initiates a resident discharge, the facility must provide written notification of the discharge-in a language and manner the resident can understand-to the resident, the resident representative (if applicable), and a representative of the Long-Term Care Ombudsman Program, at least 30 days before the intended discharge date .</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44671</p> <p>Based on interviews and record review the facility failed to ensure the comprehensive care plan described the services that were to be furnished to attain or maintain the residents' highest practicable physical, mental, and psychosocial well-being for 1 of 5 residents (Resident #1) reviewed for comprehensive care plans.</p> <p>The facility failed to ensure Resident #1's comprehensive care reflected Resident #1's resolved at risk for elopement goal of the date initiated, revised, and target. Resident # 1's goal was left blank on the comprehensive care plan.</p> <p>This deficient practice could place residents at risk for not reaching their goals due to inaccurate care plans.</p> <p>Findings included:</p> <p>A record review of Resident #1 's face sheet undated reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #1's diagnoses were Alzheimer's disease (type of dementia that affects memory, thinking, and behavior), dementia (memory loss), and major depressive disorder (loss of interest in activities).</p> <p>A record review of Resident #1's Quarterly MDS assessment, dated 09/26/2024, reflected the resident had a BIMS score of 3, which indicated severe cognitive impairment.</p> <p>A record review of Resident #1's care plan, dated 12/27/2024, did not reflect the resolved at risk for elopement related to or the goal. Resident #1's goal did not reflect the date initiated, revised, or target date of when the at risk for elopement was resolved.</p> <p>During an interview on 12/27/2024 at 12:45 p.m., the FM stated Resident # 1 was discharged from the facility 12/10/2024 when she was sent out to the hospital. Resident # 1 was discharged from the hospital on 12/13/2024 to another nursing facility the same day she was released from the hospital.</p> <p>During an interview with the DON on 12/27/2024 at 5:45pm, The DON stated that she was responsible for making sure the care plan was accurate. The DON stated there may had been a glitch that she was not aware of with the PCC . The DON stated the goals dates automatically update when updates are made to the care plan and when they are resolved . The DON stated the goals on the care plan should include the date initiated, revised, and target date. The DON stated when the care plans are not accurate the resident's needs and goals are not met.</p> <p>During an interview with the OM on 12/27/2024 at 6:00 pm, The OM stated that it was the DON's responsibility to make sure the care plans are accurate. The OM stated it was expected for the care plan focus , goals, and interventions to be updated when there was a change to the care plan. The OM stated when the care plans are not updated the need of the resident would not be met.</p> <p>(continued on next page)</p>		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A record review of the facility's Care Plans, Comprehensive Person-Centered policy, revised 2022, reflected A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident.		